TRIAD IMAGING
High Field Open MRI Multislice CT

Triad Imaging Inc.
2705 Henry Street
Greensboro, NC 27405
(336) 272-2162 fax (336) 272-2876

PATIENT: Mullins, Michael
DOB: 1/19/1968
MRN: 1200215368
PHYSICIAN: ~~Victor Freund, MD~~ V. Neavl.
DATE: 8/14/2012

EXAM: FLEXION EXTENSION LUMBAR SPINE X-RAY SERIES

HISTORY: Backache and numbness.
TECHNIQUE: Lateral neutral, extension and flexion views of the lumbar spine were obtained.

FINDINGS: Five lumbar vertebrae are assumed. Subtle retro L5 vertebral sublux in the neutral and extension position appears to reduce to neutral position in flexion. There is marked L5-S1 disc space narrowing with vacuum phenomena. Moderate L5 spondylosis. Hypertrophic changes and increased density of the posterior L5-S1 articulating facets. The remaining disc spaces are well-maintained. The lumbar vertebrae are normal in height and density.

IMPRESSION: Mild retro L5 vertebral sublux in neutral and extension views reduces in flexion. Moderate L5-S1 degenerative osseous and degenerative disc changes.

Mary L. Phillips, MD
MP / rg
DD: 8/14/2012
DT: 8/14/2012
Job: 15677485
This document has been electronically reviewed and signed by Mary L. Phillips, MD.

A

HIGH POINT SURGERY CENTER

HIGH POINT SURGERY CENTER

PATIENT NAME: MULLINS, MICHAEL B
PHYSICIAN: WILLIAM R OWINGS MD

ACCOUNT NUMBER: 1224200078
DOB: 01/19/1968

DATE OF OPERATION: 09/06/2012

HISTORY OF PRESENT ILLNESS: Mr. Mullins is referred to us today for a lumbar epidural steroid injection by Dr. Neave. Mr. Mullins has known spondylolisthesis resulting in bilateral lumbar radiculopathy. The proposed procedure of the epidural steroid injection was discussed with the patient and consent was obtained.

PROCEDURE: The patient was then brought to the Operating Room and placed in the sitting position. Monitors were applied and the patient was given IV sedation consisting of Versed 2 mg and fentanyl 50 mcg. The patient's back was then prepped and draped in sterile manner. Local anesthesia was administered using 1% lidocaine. The epidural space was located by loss of resistance using an 18-gauge Touhy needle at the L4-L5 interspace. At this point, Depo-Medrol 160 mg and Xylocaine 1% 3 mL was injected without complication. The patient tolerated the procedure well and was transferred to the PACU in stable condition.

_____
WILLIAM R OWINGS MD

WRO/HN
CONFIRMATION #: 013267
DICTATION ID #: 297647

D: 09/06/2012 13:55:45
T: 09/06/2012 19:41:34

cc:

cc: VICTORIA NEAVE MD

HIGH POINT SURGERY CENTER

PATIENT NAME: MULLINS, MICHAEL B
PHYSICIAN: WILLIAM R OWINGS MD

ACCOUNT NUMBER: 1224200080
DOB: 01/19/1968

DATE OF OPERATION: 09/19/2012

Mr. Mullins returns today for a repeat epidural steroid injection. From his first injection done September 6, he reports improvement in his pain, primarily from his right leg, but he continues to have some numbness and some mild discomfort in that right leg. The same procedure was discussed with the patient, and consent was obtained for lumbar epidural steroid injection.

The patient was brought to the Operating Room. IV and monitors were placed. The patient was placed in the sitting position and given IV sedation consisting of Versed 2 mg and Fentanyl 50 mcg. The patient's back was then prepped and draped in a sterile manner. Local anesthesia was administered using Xylocaine 1%. The epidural space was located by loss of resistance at the L4-L5 interspace using an 18-gauge Tuohy needle. At this point, Depo-Medrol 160 mg and Xylocaine 1% 3 mL was injected without complication. The patient tolerated the procedure well and was returned to the Recovery area in stable condition.

WILLIAM R OWINGS MD

WRO/4N
CONFIRMATION #: 087570
DICTATION ID #: 300709

D: 09/19/2012 15:14:18
T: 09/19/2012 18:49:14

cc:

cc: VICTORIA NEAVE MD

Initial Consult

Patient: Michael Mullins
Age/DOB: 45, 01/19/1968

MRN: 338520
Enc: 08/14/2012

#1. Arrange L-spine 4 view lateral x-rays: supine, standing, flexion, extension.
#2. Pt to call in a few days for report and recommendations.
#3. Pt would like to hold off on ESI at this time; will call if he decides he would like a referral for this.
#4. No return appointment is given at this time.

Signatures
Electronically signed by : Ann Horton, PA; Aug 14 2012 11:10AM (Author)

Established

Reg Phys Neurosurgery

Patient: Michael Mullins
Age/DOB: 45, 01/19/1968

MRN: 338520
Enc: 09/24/2012

Chief Complaint
1. Back Pain

Reason For Visit
The patient presents to the office for follow-up .
Date of Injury or Onset: 20 yrs ago
The patient is being seen at the request of Marty Mortimer PA.
Primary Care Provider: Dr Al Hawks

History of Present Illness

Michael Mullins presents with complaints of gradual onset of occasional episodes of mild bilateral lower back back pain, described as dull, aching, burning, stinging and tingling, radiating to the left buttock, left thigh, left lower leg and left foot. On a scale of 1 to 10, the patient rates the pain as 4.
Associated symptoms include leg numbness left tigh. Patient in office for lower back pain that radiates down left leg with numbness in tigh and to f/u ESI done on 09/19/12. He states that the pain is better since injections. He has had increased pain today due to sitting more. Pain level today is a 4.

HPI
Pt is a 44 y/o WM who returns today 5 days after a second L-spine ESI. He underwent the first one two weeks prior to that. He states he was doing quite well until today when he thinks he may have worsened his symptoms by sitting at his desk at work all day. He states he does better when he's up and about.

Pt has left LBP that radiates into his left buttock and occasionally into his left anterior thigh. He has left knee pathology for which he is planning another arthoscopic surgery in the near future for loose cartilage.

Pt had undergone L-spine flexion/extension x-rays which demonstrated mild L5-S1 retrolisthesis that reduces with flexion; moderate L5-S1 spondylosis and facet arthropathy.

Surgical History
1. History of Colostomy
2. History of Hernia Repair
3. History of Knee Surgery

Family History
1. Family history of Abdominal Migraine Headache
2. Family history of Acute Myocardial Infarction V17.3

Social History
1. Alcohol Use
2. Marital History - Currently Married
3. Never A Smoker

Allergies
1. Morphine Derivatives
2. Penicillins
3. Sulfa Drugs

Active Problems
1. Backache 724.5
2. Hypercholesterolemia 272.0
3. Migraine Headache 346.90
4. Numbness (Hypesthesia) 782.0

Established

Patient: Michael Mullins **MRN:** 338520
Age/DOB: 45, 01/19/1968 **Enc:** 09/24/2012

5. Red Blood In Bowel Movement (Hematochezia) 578.1
6. Spondylolisthesis 738.4

Current Meds
1. Crestor 20 MG Oral Tablet; TAKE 1 TABLET DAILY; Therapy: (Recorded:14Aug2012) to
2. Lovaza CAPS; 1 CAP 3 TIMES DAILY; Therapy: (Recorded:14Aug2012) to
3. Meloxicam 15 MG Oral Tablet; TAKE 1 TABLET DAILY WITH FOOD; Therapy: (Recorded:14Aug2012) to

Review of Systems
Complete ROS which was performed during a previous encounter was re-examined and reviewed with the patient. There is nothing new to add today. For details, please refer to my previous note in this chart, dated: 08/14/2012.

Vitals
Vital Signs - Basic [Data Includes: Current Encounter]
BMI Calculated: 30.81
BSA Calculated: 2.45
Height: 6 ft 4 in
Weight: 253 lb
Blood Pressure: 137 / 82
Temperature: 97.3 F
Heart Rate: 74
Respiration: 16

Physical Exam

Description: White male well groomed and overweight. **Affect:** In no acute distress.
Sitting on edge of examination table with for comfort.

Mental Status: alert & oriented.
Speech: clear and fluent.
Recall: normal.

Skin: dry and warm.

HEENT Exam:
Head: normocephalic and atraumatic.
Sclerae/Conjunctivae: clear and anicteric.

Gait: antalgic - left.

Results/Data
All Results [Data Includes: Last 1 Hour]
No recent results.

Impression
1. Backache 724.5
44 y/o overweight WM who has had L-spine ESIs x 2. He felt he had good effect until today when he "over-did it" by spending too much continual time at his desk. He hopes his worsening symptoms will improve over the course of the next few days as he plans to get up and walk about more when he can at work.

At this point, he would like to take a watch and wait strategy to his symptoms. He will call in a few weeks if he continues with symptoms, or they worsen. He will have to bring his MRI CD by so that I may discuss his case further with Dr. Neave, should he not

Established

Patient: Michael Mullins **MRN:** 338520
Age/DOB: 45, 01/19/1968 **Enc:** 09/24/2012

improve or his symtpoms worsen.

Plan
#1. Pt to call in 2-3 weeks; if no improvement, will bring by CD of MRI to discuss with Dr. Neave for further recommendations.
#2. No return appointment is given at this time.

Signatures
Electronically signed by : Ann Horton, PA; Sep 24 2012 5:13PM (Author)

Initial Consult

Reg Phys Neurosurgery

Patient: Michael Mullins
Age/DOB: 45, 01/19/1968

MRN: 338520
Enc: 08/14/2012

Chief Complaint
1. Back Pain

Reason For Visit
The patient presents to the office for initial evaluation .
Date of Injury or Onset: 20yrs ago
The patient is being seen at the request of Marty Mortimer PA-C.
Primary Care Provider: Dr Al Hawks
The patient has received medical care since last appointment: .

HPI

Michael Mullins presents with complaints of gradual onset of constant episodes of mild left > right and bilateral lower back back pain, described as aching, burning, stinging and tingling, radiating to the left buttock and left thigh. On a scale of 1 to 10, the patient rates the pain as 2. Episodes started about 2 months ago. He is currently experiencing back pain. Symptoms are improved by NSAIDs. Symptoms are made worse by prolonged sitting. Symptoms are unchanged. Risk Factors: no obesity, no recent serious infection, no recent trauma, no sedentary lifestyle and no smoking. Pertinent Medical History: DJD of back, but not herniated disc(s). Associated symptoms include leg numbness Left lateral thigh and stiffness , but no abdominal pain, no arm numbness, no arm weakness, no crepitus, no decreased range of motion, no fecal incontinence, nofeeling of instability, no fever, no general malaise, no leg weakness, no night sweats, no rash localized to the area of pain, no spasm, no urinary incontinence, no urinary retention and no weight loss. Complaints of lower back pain that radiates into both legs occasionally. He is an prior patient of Dr Neave's (~15 years ago). Pain level today is 2/10.

Previous Evaluation/Treatment: medications NSAIDs and injections ESIs about 15 years ago - helped some

History of Present Illness
Pt is a 44 y/o WM here for evaluation of LBP that radiates some into his left buttock. About two months ago, he found that his left lateral thigh was numb with occasional burning sensation. There was no specific injury. He has noticed no waxing or waning of the symptoms. He denies either LE weakness; no change in bowel or bladder. Pt's primary concern today is the subluxation found on the MRI. He notices increased LBP when he sits for awhile or if he has to lean forward in his chair as he does for his job.

Pt had seen Dr. Neave about 15 years ago for similar symptoms. He states at that time, he underwent a series of L-spine ESIs which help alleviate his pain symptoms.

Pt works as chief MRI technician for Triad Imaging. He has never smoked. He enjoys playing golf and kayaking, neither of which he has done for the past two months with his current symptoms. He takes meloxicam 15mg qd for his arthritis. He is status post left knee ACL reconstruction and subsequent debridement via arthroscopy x 2.

Past Medical History
Patient denies any pertinent past medical history associated with the current complaint.

Surgical History
1. History of Colostomy
2. History of Hernia Repair
3. History of Knee Surgery

Family History
1. Family history of Abdominal Migraine Headache
2. Family history of Acute Myocardial Infarction V17.3

Social History
1. Alcohol Use
2. Marital History - Currently Married
3. Never A Smoker

Initial Consult

Patient: Michael Mullins
Age/DOB: 45, 01/19/1968

MRN: 338520
Enc: 08/14/2012

Allergies
1. Morphine Derivatives
2. Penicillins
3. Sulfa Drugs

Active Problems
1. Backache 724.5
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4. Red Blood In Bowel Movement (Hematochezia) 578.1

Current Meds
1. Crestor 20 MG Oral Tablet; TAKE 1 TABLET DAILY; Therapy: (Recorded:14Aug2012) to
2. Lovaza CAPS; 1 CAP 3 TIMES DAILY; Therapy: (Recorded:14Aug2012) to
3. Meloxicam 15 MG Oral Tablet; TAKE 1 TABLET DAILY WITH FOOD; Therapy: (Recorded:14Aug2012) to

Review of Systems

Constitutional: no recurrent or persistent fever, no MRSA and no cancer.
Eyes: does not wear glasses, not nearsighted, not farsighted, no cataract right eye, no cataract left eye and no glaucoma.
Ears, Nose, Throat & Mouth: no right hearing aid, no left hearing aid, no right hearing loss, no left hearing loss, no ringing in right ear, no ringing in left ear, no balance disturbances, no sinus problems, no sinus headaches and no sore throats.
Cardiovascular: high cholesterol, but no chest pain/angina, no acute myocardial infarction, no heart failure, no previous open heart surgery, no previous heart stents, no high blood pressure, no low pressure, no irregular pulse, no heart murmur, no swelling in hands or feet, no leg pain while walking and no rheumatic fever/infections.
Respiratory: no asthma, no chronic cough, no emphysema, no dyspnea, no bronchitis, no pneumonia, no blood clot in lungs, no tuberculosis, negative TB skin test, no lung cancer, no sleep apnea, no use of CPAP/BiPAP and no oxygen use.
Gastrointestinal: blood in stool, but no indigestion/heartburn, no nausea, no vomiting, no liver disease or hepatitis, no gallbladder disease, no change in bowel habits, able to control bowels, no ulcers or gastritis, no irritable bowel syndrome and no colon cancer.
Genitourinary: no frequent urinary tract infections, no hematuria, no prostate enlargement, able to control urine, no kidney stones, no prostate cancer, no bladder cancer, no uterine cancer, no cervical cancer, no sexually transmitted disease, no renal failure and no dialysis.
Musculoskeletal: right leg weakness, left leg weakness, back pain and arthritis, but no broken bones, no right arm weakness, no left arm weakness, no right arm pain, no left arm pain, no right leg pain and no left leg pain.
Integumentary: no skin disease, no skin cancer, no right breast cancer and no left breast cancer.
Neurological: migraine headaches, but no seizures, no loss of consciousness, no head injury, no frequent headaches, no memory problems, no speech difficulties, no double vision, no facial weakness, no facial pain, no change in voice, no difficulty swallowing, no problems with coordination of arms, no problems with coordination of legs, no difficulty walking, no stroke, no tremors, no Parkinson's disease and no meningitis/infections.
Psychosocial: no anxiety, no depression, no claustrophobia and no psychiatric disorder.
Endocrine: no diabetes, no thyroid disease and no hormone problems.
Hematologic/Lymphatic: blood transfusions (2009), but no anemia, no bleeding tendencies/easy bruising, no persistent swollen lymph nodes or glands, no HIV/AIDS and no leukemia/lymphoma.
Allergic/Immunologic: seasonal allergies, but no food allergies and no immunologic disorders.

Vitals
Vital Signs - Basic [Data Includes: Current Encounter]
BMI Calculated: 30.81
BSA Calculated: 2.45
Height: 6 ft 4 in
Weight: 253 lb
Blood Pressure: 134 / 89

Initial Consult

Patient: Michael Mullins
Age/DOB: 45, 01/19/1968

MRN: 338520
Enc: 08/14/2012

Temperature: 97.1 F
Heart Rate: 87
Respiration: 18

Physical Exam

Description: White male well groomed and normal weight. **Affect:** In no acute distress.

Mental Status: alert & oriented.
Speech: clear and fluent.
Recall: normal.

Skin: dry and warm.

HEENT Exam:
Head: normocephalic and atraumatic.
Sclerae/Conjunctivae: clear and anicteric.
Nose: nose is normal.
Dentition: good .
Tongue: normal .

Cranial Nerves Exam:
Cranial Nerve 2: normal.
Cranial Nerve 3: normal.
Cranial Nerve 4: normal.
Cranial Nerve 5: normal.
Cranial Nerve 6: normal.
Cranial Nerve 7: normal.
Cranial Nerve 8: normal.
Cranial Nerve 9: normal.
Cranial Nerve 10: normal.
Cranial Nerve 11: normal.
Cranial Nerve 12: normal.

Lungs: clear.
Cardiovascular: regular rhythm. Heart rate is normal. Normal S1 and normal S2.

Extremities: no cyanosis, no edema, no clubbing and no deformity.
Muscle Bulk: normal.
Range of Motion: normal.

Musculoskeletal:
Visible Deformity: None. Palpable Deformity: None. Spine Tenderness: none. Sciatic Notch Tenderness: left, tenderness is mild. Sacroiliac Joint Tenderness: none. Greater Trochanter Tenderness: none. Muscle Tenderness: none. Muscle Spasm: none. Spine Range of Motion: full. Associated Symptoms with ROM testing: increased left buttock pain with flexion and turning left. Right Straight Leg Raising: negative. Left Straight Leg Raising: negative. Right Patrick's Maneuver: negative. Left Patrick's Maneuver: negative.

Motor Exam:
Right Hip: No right hip weakness .
Left Hip: No left hip weakness .
Right Knee: No right knee weakness.
Left Knee: No left knee weakness .
Right Ankle: No right ankle weakness .
Left Ankle: No left ankle weakness .
Right Great Toe: No right great toe weakness.
Left Great Toe: No left great toe weakness.

Initial Consult

Patient: Michael Mullins **MRN:** 338520
Age/DOB: 45, 01/19/1968 **Enc:** 08/14/2012

Pt is able to walk on the balls of his feet/heels as well as squat/stand wtihout evidence of weakness.

Reflexes:
Right Leg: right knee jerk 2+/4 and right ankle jerk 1+/4.
Left Leg: left knee jerk 2+/4 and left ankle jerk 1+/4.
Toes - Right: right toes downgoing.
Toes - Left: left toes downgoing.
Ankle Clonus - Right: ankle clonus 0 beats on the right.
Ankle Clonus - Left: ankle clonus 0 beats on the left.
Muscle Tone - Right Leg: right leg muscle tone normal.
Muscle Tone - Left Leg: left leg muscle tone normal.

Sensory Exam:
Right Leg: light touch sensation normal, pin prick sensation normal, proprioception normal and vibratory sensation normal.
Left Leg: light touch sensation decreased, pin prick sensation decreased, proprioception normal and vibratory sensation normal.

Pt reports decreased sensation to LT and PP to lateral left thigh.

Cerebellar: normal.

Gait: normal.

Results/Data

All Results [Data Includes: Last 1 Hour]
No recent results.

Radiology

L-spine MRI 7/31/12 at Triad at Church is reviewed: Normal lordosis; some retrolisthesis of L5 on S1; DDD at L5-S1 with central mild disk bulge; some left foraminal narrowing at L4-5.

Impression

1. Spondylolisthesis 738.4
2. Numbness (Hypesthesia) 782.0

44 y/o WM with LBP and left lateral thigh numbness x 2 months.

L-spine MRI reveals some retrolisthesis of L5 on S1 with DDD and disk bulge at this level without nerve root impingement. Physical exam reveals adequate BLE strength and DTRs intact; decreased sensation to lateral left thigh to LT and PP.

Discussion is had concerning obtaining dynamic L-spine x-rays to ascertain stability. We discussed ESI to see if it would alleviate the LLE symptoms. Pt states he would like to hold off on the latter at this point but will let us know if he decides to pursue this referral. Pt is interested in increasing his activities. He understands that should the dynamic x-rays reveal stability, he will be able to do this. Pt is amenable to this plan.

Plan

1. Referral Workup Outpatient Referral Requested for: 14Aug2012
   Please arrange L-spine 4 view lateral x-rays: supine, standing, flexion, extension.Pt to call in a few days for report.Pt would like to hold off on ESI at this time; will call if he decides he would like a referral for this.